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ABSTRACT

Real depression in children can manifest itself in many ways. Every human being is somewhat different and consequently distress signals and breaking points do not always imitate each other. What remains constant is the internal emotional desert and emptiness. Depression is not just feeling sad or lethargic. Depression is a state in which self-esteem and self-worth are severely impoverished or sometimes completely lost, combined with longstanding and unresolved conflicts built around hostilities which generally tend to be turned inwards. Until recently, children were regarded as having a mental organization not mature enough to experience the quality of depression. Non-depressed children will believe they are worthy of the desired goods, but they are deprived of them; depressed children will feel unworthy of the coveted gratifications. Possible signs of depression include when the child: (1) is extremely self-critical; (2) has an extremely vigilant conscience; (3) needs to be perfect; (4) feels persecuted; (4) is passive, inhibited, and unassertive; or (5) feels lonely and has poor relationships. Motivational factors in suicide include a desire to escape from an emotionally or physically intolerable situation, a hostile gesture, or severe ego disintegration. A disturbance in the early relationships of a child in which the child experiences rejection, may result in a lack of gratification, anger, and feelings of worthlessness. (Four case samples are included.) (ABL)

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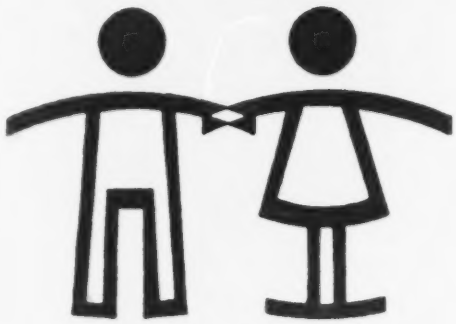

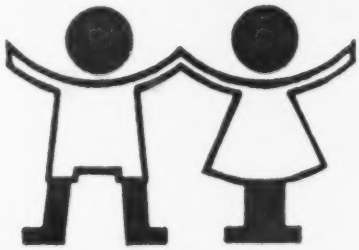

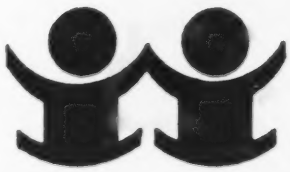

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RECOGNITION OF DEPRESSION IN THE PRIMARY SCHOOL CHILD

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RECOGNITION OF DEPRESSION IN THE PRIMARY SCHOOL CHILD

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INTRODUCTION

The aim of this paper is to help professionals who, in their varied roles, come into contact with children, by drawing to their attention the factors to look for in the recognition of depression in the primary school child. However, before I can describe its indicators or signs, I will first have to say something about the nature of depression and a little about its aetiology.

While I will be listing signs to look for at a later stage in this paper, what I would like you to be able to take away in the end is not so much a complete list of clusters of symptoms, but a basic understanding, or at least some insight into what is going on inside the child who is genuinely depressed. That is the most important thing. For the emotional dehydration of all positive things inside the child - and that is what real depression is all about - can manifest itself in myriads of different ways and not just the ones that I will be mentioning. Every human being is somewhat different and consequently distress signals and breaking points do not always imitate each other. What remains constant however, is the world behind the symptoms - the internal emotional desert and emptiness.

It is our job to recognise this emptiness, this dehydration of good things and the loss of self-respect and differentiate some of its symptoms from other forms of emotional distress with which depression may share some of its symptoms, but not its pathology.

WHAT DEPRESSION IS NOT

Depression is not just feeling:

- sad
- lonely
- lethargic
- alone
- sapped of energy
- gloomy
- dejected
- unhappy

These feelings, with other intra-psychic concomitants, could be part of every day existence or other emotional pathologies. Some of the symptoms of depression (low energy level, impaired thinking, etc) could also of course be related to physical rather than emotional factors primarily, so it is important that all possible physical causes are excluded.

Some of the possible physical involvements that could have depressive symptoms as corollaries, though they are not the primary factors, include general systemic disease (eg. malignancy, chronic infectious disease, viral infections, hypothyroidism, hypoadrenalism, chronic anemia, subnutrition), toxins (eg. chronic intoxications with anticonvulsants or sedatives) and degenerative central nervous diseases.

However, endogenous depression (a deviation of biological function induced by genetic and biochemical factors) in children is reported very rarely or not at all.

WHAT DEPRESSION IS

I shall give some kind of a makeshift description and definition here to start with. It is going to be makeshift because any definition simplifies matters too much; however definitions are important to encapsulate a primary understanding from which to branch out for further questioning and elucidation.

Depression then, in its true sense, is not just a mood change, a feeling low, a sap of energy but a state in which self-esteem and self-worth are severely impoverished or sometimes even completely lost, combined with longstanding or unresolved conflicts built around hostilities which generally tend to be turned inwards.

Unfortunately, however, the general understanding and concept of childhood depression even amongst professionals is not clear cut. This is partly because the awareness of depression in children as an entity is a comparatively recent one and partly because this term has been - and continues to be - rather vaguely used and defined.

Until comparatively recently, children were regarded as having a mental organisation, not mature and developed enough, to experience the quality of depression. This was of course because depression was viewed from the point of view of adult psychiatry. The tendency had been (and alas, often remains) to work back from the adult, rather than the more natural and appropriate way, in my opinion, to work from the child towards the adult. This is, I believe, an important basic concept for it is always the child in us that needs to be understood even when the breakdowns are in the "adult" stages of our lives.

In any case it was about 30 years ago that Spitz, (1945-1947), Bowlby (1969) and others described the despair of institutionalised infants who were abruptly separated from their parents. The state of despair that these children experienced as a result of the loss of the relationship with key figures in their lives was termed, quite correctly, a form of depression. (By key figure I mean primary, important, on-going care-takers in any infant's/child's life). However, by the 1970s the term depression was used in a number of different and confusing ways. Nurcombe and Gallagher (1986) bring attention to this fact, and list a number of ways in which the term "Depression" has been used in the past (and sometimes, in my opinion, misused). Nurcombe and Gallagher remind us that:

1. The term depression was applied to clinically observable states of emotion and behaviour, for example: distress, regressions, affect withdrawal, emotional/physical immaturity which were found in children who have experienced separation from the primary caretaker after about six months of age.

2. The term depression was sometimes also applied to children who manifested a fidgety impatience, anxiety and restlessness (dysphoria) concurrent with complaining of being unhappy.

3. Depression was also said to include a cluster of behaviour patterns, characterised by anger, emotional lability, suicidal ideation (and suicide is not always depression!) and poor academic record, following or concurrent with chronic loss of or rejection by key figures, or exposure to severe family disruption.

The important issue here is that in all these instances a cluster of behaviours was labelled depression, often without the actual reason, motivation or underlying aetiology being ascertained or defined.

This is analogous to saying that everybody who has a headache suffers from a brain tumour. Some headaches, no doubt, are related to brain tumours but most are not and the symptom of the headache says very little about its aetiology or the remedial steps that need to be taken.

So if we talk of depression and its symptoms, what we really have to clarify is whether the symptoms we are observing are related or bound up with a severe lowering or loss of self-esteem. If the answer is yes, we are talking about true depression, if the answer is no then we are possibly talking about another pathology (or no pathology at all) which is simply sharing the same symptoms.

One important, distinguishing factor is that true depressives deep inside blame themselves for all their woes and pain and not the world and not somebody else outside. In a simplistic but profound way really depressed children will hate themselves for all that is going wrong in their lives and will believe that the rest of the world is justified for shunning them or for regarding them as failures and for not being "deserving" of successful relationships etc. They will hate themselves in a kind of totality, mercilessly and unrelentingly. The truly non depressives (who may have their own, but other problems) will hate the world for not having given them support, for all the bad times .... In short, the truly non depressive will direct his/her anger to the world outside, while the depressed child will hate him or herself.

Non-depressed children will believe that they are worthy of the desired goods, but they are deprived of them; truly depressed children will feel unworthy of the coveted gratifications, be it success, love, relationships or whatever.

Concurrent and equally important is the strong lack of real inner creativity. These children - the truly depressed - feel totally worthless and consequently they are incapable of innovations or play, or of just being themselves. One can see this quite often with children who are unable to play and unable to create with toys or aspects of the environment about them.

Because these children view themselves as bad and worthless, they are also devoid of hope. If there is no goodness or value in themselves and nothing within them to be cherished, loved or worthy of respect, then there is nothing one can expect. If there is nothing there is no hope. Without hope there can be no growth or learning, for learning means reaching out and exploring both the physical and the emotional environment.

Because of their low self-esteem the depressed child will tend to withdraw from conflict. In the most severe cases (though this is not always necessary) the depressed child is passive, unassertive and often scapegoat material.

Depressed children are likely to have difficulties dealing with their anger for to be angry will make them feel even less worthy since they see themselves in all situations as the "baddie" and the world out there the coveted "goodie". Their anger is never acceptable to them.

In short, these children tend to be markedly guilt ridden, because they feel that there is so little that is good about them that it is only a matter of justice that nobody loves them. They feel alone, unloved and unworthy of love.

In giving you this picture I am talking about what I consider real depression, what I see as "chronic" depression. This is depression that has been going on for a long time and obviously has its origins in the experienced quality of the child's early relationships with his or her key figures.

Children, like adults, can react to threats to their well-being or to real or perceived losses of important figures in their lives with symptoms very similar to those of true depression. But if they have a healthy and viable emotional core they will be able, in the long run, to cope with adversities better or faster than the truly depressed. In the case of the non-depressed children, the threat to their self, to their real totality, their identity is never quite as lethal. Their losses will hurt, but these losses do not attack the child's self-concept, self-respect or identity as they do in the case of the truly depressed child.

POSSIBLE SIGNS OF DEPRESSION

I would like to move on to outline some of the signs to watch out for as possible indicators of depression. These are when the child:

1. Is extremely self-critical.
2. Has an extremely vigilant conscience (super-ego).
3. Needs to be perfect.
4. Feels worthless.
5. Is unable to ventilate aggression in a healthy way and is afraid of, or ashamed of, his or her own aggression.
6. Feels unloved, unlovable.
7. Feels persecuted.
8. Is excessively self-conscious.
9. Appears tense, tearful and generally worrying, unhappy.
10. Feels lonely and has poor relationships.

11. Is extremely dependent, or would be dependent on others in a way that is outside age-appropriate limits.
12. Exhibits feelings of hopelessness.
13. Lacks spontaneity and inner creativity.
14. Shows overall, noticeable despair.
15. Is preoccupied with real or feared losses.
16. Shows evidence of slowed down thought processes.
17. Underachieves at school.
18. Is passive, inhibited and unassertive.
19. Engages in antisocial behaviour which may be a cry for help or may be a way of hurting him/herself.
20. Attempts or fantasises suicide. (Suicide, attempted suicide and fantasised suicide are sometimes but not always indications of depression. Consequently motivation for suicide needs to be closely queried in all actual attempted or fantasised instances before suicidal attempts or ideation are linked with depression, although all gestures and statements should always be taken seriously).

Motivational Factors in Suicide:

a) Desire to escape from an emotionally or physically intolerable (family?) situation.
b) To signal distress - to let the world know of the pain and distress. A plea for help.
c) A hostile gesture - to manipulate or punish others. An act of hostility against a rejecting "world" or key figure.
d) To punish self for the perceived worthlessness and lack of hope for the future.
e) To seek reunion, for example with a lost or idealised dead relative. (This also offers escape from the present intolerable situation).
g) Severe ego disintegration, for example some psychotic states.

Having listed these factors, I must reiterate that their existence,either singly or in multiples, does not necessarily imply the presence of real depression. One always needs to ascertain whether these indicators are primarily linked with a severe lowering of self esteem. If the aetiology behind these manifestations suggests a severe lowering of self esteem, plus crippling problems with dealing with aggression, then we are faced with a true clinical depression.

If not, the answers do not lie in real depression.

CASE EXAMPLES

I would now like to provide some case examples in which I can point out relevant and significant clues to depression observable in the everyday lives of four children who have been referred to me.

CASE 1

Boy aged eleven and a half referred by his mother who reported that he exibited the following behaviours:

- Low self esteem.
- Sensitivity.
- Tearfulness at school.
- Poor relationship with his father.
- Poor school work.
- Increasing tantrums.
- Yelling, crying, throwing things around, escaping to roof after arguments ("to cool off"). He says "Nothing goes right", "No one cares", "I don't fit in anywhere".

The reported low self-esteem, the sensitivity, the tearfulness, the poor relationship with a key figure, the poor academic achievement and the increasing volatility (signs of stress) would fit in with the depressive syndrome. An even more important clue, even at this early stage, is the reported need to escape from arguments "to cool off" (problems with healthy ventilation of aggression) and the implications of worthlessness and self blame that come through the reported statements about the self by the child's mother.

On the first attendance the boy's mother also said she had found the following self-expressions, which were written by the boy on three different occasions.

GOOD POINTS	BAD POINTS
I can draw.	I can't design anything. I can't spell. I am always picked last. I can't cope with life. I'm always in the wrong: never in the right. Hardly anyone wants to talk to me like mum. I am lazy. I can't make the cricket team. I am hopeless at sport. I am an idiot. I am not a peaceful person. I am spoiled too much. I can't stop lying to my friends. I should not be trusted. I don't eat my lunch and it goes off. I don't close the fridge. I am too wimpish for my age. When I am hurt, they think I am carrying on.

MY WILL

Helmet and bike:	David and John.
My games:	Foster homes -spastic centre.
My money:	Mum and Gran.
My toys/books:	Smith Family.
My drawings:	Who ever wants them.
My clothes:	St. Vincent de Pauls.
Body:	Cemetery and bugs.

REASONS

I am always at the bottom of the list.
I am not very happy about life.
I don't deserve life itself.
I am used by people.
I don't like myself.
I can't make a team for my school.
I give up too easily.

Of course very few cases are as dramatically clear cut as this but nonetheless one can see here clearly and unmistakably the child's pain, his strong sense of worthlessness, the total sense of self-blame, his concurring with the rest of the world that he is no good, the extreme self-criticalness and the very little that he can find good, respectable and lovable about himself. The world out there is all right, it is he himself who is worthless and not worthy, as he says, "of life itself". Note that the only comparatively good thing - his drawings, the only positive thing he can find about himself - is not regarded as being worth much. They are left to "anybody" who wants them.

CASE 2

Boy aged five and a half referred by Medical Officer. The following information, which is relevant for our purposes, was reported:

- One of triplets. Other two died at birth.
- Mother is a drug addict.
- Child in foster care on and off from age 18 months, including one of six and two of nine month periods. Currently living with maternal grandmother.
- Nightmares - every night.
- Soiling everyday.
- Aggressive behaviour at school.
- Falls asleep in class - up to two hours.
- Teacher at pre-school found that if she corrects child with regards to school work he tends to punish himself by scratching his arms, etc.

The nightmares, the soiling, the aggressive behaviour at school, the tiredness could all be part of a depressive disposition, but what would make me suspect depression even more would be the conjunction of the above with the fact that the child is reported to punish himself after being chastised or found to be "lacking", or not up to standard. What one suspects here immediately is that the child has already internalised his anger, tends to blame himself and already desires to punish himself (and does so) when he feels he "lets the world down".

During his first session with me he seemed particularly concerned with questions about heaven, such as its nature, whereabouts and qualities and it became obvious to me that heaven was seen by him as the refuge where he could escape from his personal losses and precarious and ambivalent home environment and unite with the idealised and coveted dead siblings.

I felt that there was a risk of suicide with this child.

Sadly, the risk became an attempted reality.

Within a short period of attendance the little boy had tried suicide by tying a plastic bag over his head. It happened at school and the school reported considerable struggle when they wanted to remove the bag from the child's head, with him saying "I want to suffocate myself".

Obviously on this occasion the child's need to punish himself and his constant preoccupation with heaven were the specific signs which alerted one to his depression.

CASE 3

Boy aged nine and a half, referred by School and School Counsellor for attempted suicide, he had tried to jump out of a second floor window. The following information was offered:

- Boy is sullen and withdrawn.
- Said to School Counsellor - "There is nothing nice in my life. I wanted to jump out to smash into a million pieces. Wouldn't matter if I hurt myself".
- Told another boy at school that he would kill himself that day.

A visit by mother to the centre offered the following additional information:

- Father is away a lot (long standing).
- Mother away long hours because of business commitments. Boy left to his own devices. (Again long standing).
- Boy was seen as unhappy and bad tempered, with little respect for himself.
- Often angry.
- Doesn't like his looks.
- Three months previously boy told mother he had watched a TV show and saw three ways of committing suicide.
- Feels no-one at school likes him.
- Stole money - to buy friendship.

The above information would suggest the inner emptiness and dehydration of good things that I talked about earlier. "There is nothing nice in my life" he says. He doesn't like his looks, feels no-one at school likes him, and he feels he is unlovable (needs to buy friendship).

The specific interest in ways of dying and committing suicide (as related to Mother) and the reported unhappiness, bad temper and anger would also suggest problems in dealing with his own anger in a healthy enough way. With parents being "chronically" away and the boy being left to his own devices, there is obviously also little support or chance of sufficient (experienced) emotional nurturance.

When seen by me the aspects of guilt, self-blame and the strong unresolved problems with his own aggression (angry feelings) became infinitely clear through his own description of the reasons for attempted suicide. He related how angry he got with himself that day, for "getting angry". He had been angry with the whole class. He felt he was going to do something because of this anger and yet he didn't want to "disturb" the class. Through jumping out the window he wanted to get rid of all the anger and, as he so aptly put it, in so doing he wanted "to put the goodness back in". Unconsciously this child knew what he needed psychologically.

This child"s behaviour and motivation illustrate most clearly the tenet that depression is a combination of significantly lowered or lost self-esteem and long standing and unresolved conflicts about hostilities which basically, in the end, tend to be turned inwards.

CASE 4

Girl aged 11 referred by a Nun at her school who, in conjunction with child's mother, offered the following information, which is relevant for our purposes.

- Child is a loner.
- Slower than others.
- Frustrated with lack of success at school.
- Loses temper.
- Has had speech problems. (Now better but still self-conscious about it).
- Takes temper out on sister.
- Feels inferior at school.
- Been writing "I know I'm stupid".
  "I don't speak properly".
  "Nobody cares for me".
  "It is all my fault".
- Said to mother on the morning of attendance with me: "I've only one question to ask the doctor. What am I supposed to do when I get cranky?"

Once again, the information suggests a child who views herself in a poor light, with little respect for herself. The poor peer relationships, the frustrations and self-dissatisfaction together with the general lack of academic success, the (unfounded, since the problem is now resolved) self-consciousness about the past speech problem, the general feelings of inferiority and the written verbalisations of dissatisfaction with herself, all would suggest a considerable lowering of self-esteem.

However, what is even more revealing, or at least in conjunction with the above, is the child's own assessment of where, why and how she needs help from the agency that they are attending: "I've only one question to ask the doctor. What am I supposed to do when I get cranky?"

Here once again, we have a marriage of poor self concept plus guilt and inability to handle the aggressive conflict in a way that allows ventilation without destructiveness to the self.

THEORETICAL FRAMEWORK FOR THE PRECEDING OBSERVATIONS

It is not the function or purpose of this paper to go into great detail about the underlying theoretical interpretations of these children's behaviour, but I should like to briefly summarise some of the theoretical understanding which is the backbone of what I have said here about childhood depression.

Melanie Klein, (1948), Winnicott (1958, 1964, 1974, 1979) Bowlby (1969) and others have shown in their works that the early years are of particular importance in the development of both self-esteem and the ability to form relationships.

If a child's early relationships are emotionally gratifying then the child will grow up with a sound self-image and an ability to relate to others in a healthy way. The claims made for the crucial period may vary depending on the theorists, but they all agree on the importance of the early years. The first three years would seem to me to be of vital importance in the development of a core of healthy, positive self-concept.

If, in the early relationship of the child, with his or her key figure, satisfactory bonding and attachment take place through which the child can feel safe, loved, cherished, respected and that his/her needs are met, then the groundwork for the future is safe. If on the other hand factors intervene through which the child experiences the key figure as rejecting, not meeting his or her needs, unavailable, ignoring or devaluing, then the child's self concept will suffer and he or she will experience the lack of gratification as a reflection of himself or herself and his or her lack of worth. The lack of gratification will also generate anger which, since it is enhanced by some potential reciprocity from the key figure, will further augment feelings of worthlessness.

Of course all the above must be taken only as a very vague guideline. Any disturbed aspect of emotional well being or adjustment is not just a function of the experienced deprivation. It is also dependent on the balance between the deprivation's intensity and duration on the one hand, and, on the other, the psychological (internal) viability and maturity of the child during the time in which the deprivation or lack of gratification takes place.

Also, once there is a foundation of early deprivations and attacks on the child's sense of self esteem, continued assaults from actual or perceived environmental factors, such as severe family stresses or school failure, may lead to a further compounding and enhancement of early depressive trends.

CONCLUSION:

In attempting to describe and clarify the concept of true depression and its recognition in the primary school child I have listed "signs" that one can look for in the child"s everyday life, be it home or school. I have also underlined the fact that symptoms on their own do not necessarily dictate pathologies. It is the causal link that decides or defines whether a set of apparent indicators point to true depression or not. I have argued that the most significant feature of true depression in children (and in the non-endogenously depressed adult as well in my opinion) is the lowered or lost self-esteem, combined with long standing or unresolved conflicts built around hostilities which generally tend to be turned inwards.

Based on a paper presented at the Child Health Seminar, Prince Henry Hospital, Sydney in February 1988

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